BOTULISM CASE INVESTIGATION - Page 1 of 5

Indiana State Department of Health
State Form 49684 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ✓⊗
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.
6. **Date format: MM/DD/YY**

Section 1. Demographic Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth** / / **Age**

Race:
- ○ Asian
- ○ Black or African American
- ○ American Indian or Alaska Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other/Multiracial
- ○ Unknown

Ethnicity:
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

Sex:
- ○ Male
- ○ Female
- ○ Unknown

Is Age in day/mo/yr?
- ○ Days
- ○ Months
- ○ Years

Occupation **Phone of Employer/School/Day Care** - -

Name of ○ **Employer** ○ **School** ○ **Day Care**

Address of Employer/School/Day Care

City **State** **ZIP Code** -

Section 2. Clinical Information

Symptoms:
- ○ Fever . *(degrees)*
- ○ Diarrhea
- ○ Abdominal Cramps
- ○ Nausea/Vomiting
- ○ Constipation
- ○ Muscle Weakness
- ○ Dry Mucous Membranes
- ○ Double/Blurred Vision
- ○ Difficulty Speaking
- ○ Difficulty Swallowing
- ○ Descending Paralysis
- ○ Mental Status Change
- ○ Sensory Changes
- ○ Other, specify:

Date of Onset / /

Duration of Symptoms in Days

Date First Positive Specimen Collected / /

Source of Positive Specimen:
- ○ Stool
- ○ Blood
- ○ No Positive Specimen
- ○ Other, specify:

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City **State** **ZIP Code**

Physician/Hospital Phone

Was testing performed on CSF? ○ Yes ○ No ○ Unknown

If Yes, results

Was CAT scan performed? ○ Yes ○ No ○ Unknown

If Yes, results

Was a tensilon test performed? ○ Yes ○ No ○ Unknown

If Yes, results

Was electromyography performed? ○ Yes ○ No ○ Unknown

If Yes, results

Was the patient treated with antitoxin for this illness?
○ Yes ○ No

If Yes, manufacturer:

Dosage:

Was the patient hospitalized?
○ Yes ○ No

If Yes, admission date: / /

Discharge date: / /

Hospital:

Did patient die?
○ Yes ○ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 5 days prior to illness onset.

1.

Establishment Name

Address

Foods Eaten (list) **Date** / /

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Section 3. Epidemiologic Information (continued)

2. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

3. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

4. **Establishment Name**

Address

Foods Eaten (list) **Date** / /

List all group gatherings where food was served that the patient attended during the 5 days prior to illness onset.

1. **Type of Gathering**

Responsible Person

Phone Number - - **No. of Persons** **Date** / /

2. **Type of Gathering**

Responsible Person

Phone Number - - **No. of Persons** **Date** / /

List all stores where the patient bought groceries that were consumed during the 5 days prior to illness onset.

Store Name:	**Street Address:**	**Date:**
		/ /
		/ /
		/ /

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Section 3. Epidemiologic Information (continued)

Indicate whether the patient consumed the following foods or beverages during the 5 days prior to illness onset.

Food Item:	Date Consumed:	Brand Name:	Name of Place Purchased:
○ Canned Foods	/ /		
○ Vacuum-packed foods	/ /		
○ Smoked fish	/ /		
○ Baked potatoes	/ /		
○ Oil w/garlic or herbs	/ /		
○ Chili peppers	/ /		
○ Tomatoes	/ /		

Section 4. Risk Factors

During the 5 days prior to illness onset, did the patient:

Eat any home-canned or preserved (in a jar) foods? ○ Yes ○ No ○ Unknown

If Yes, which food

Where prepared

Eat any foods (leftovers) sitting out several days? ○ Yes ○ No ○ Unknown

If Yes, which food

Where prepared

Eat any "natural" foods or "health" foods? ○ Yes ○ No ○ Unknown

If Yes, which food

Where prepared

Eat any ethnic foods? ○ Yes ○ No ○ Unknown

If Yes, which food

Where prepared

Eat any foods with a foul taste or odor? ○ Yes ○ No ○ Unknown

If Yes, which food

Where prepared

Eat any foods from swollen containers? ○ Yes ○ No ○ Unknown

If Yes, which food

Where prepared

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Section 4. Risk Factors (continued)

During the 5 days prior to illness onset, did the patient:

Drink any homemade alcoholic beverages? ○ Yes ○ No ○ Unknown

If Yes, which beverage

Where prepared

Travel outside of Indiana? ○ Yes ○ No ○ Unknown

If Yes, where

Date of departure / / **Date of return** / /

Does the patient know anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain? ○ Yes ○ No ○ Unknown

If Yes, name

Relationship

Phone number - - **Onset date** / /

Was this person exposed to any of the same commercial food establishments, group gatherings, or travel history listed above? ○ Yes ○ No ○ Unknown

If Yes, describe

During the 14 days prior to illness onset, did the patient:

Sustain any cut or wound? ○ Yes ○ No ○ Unknown

If Yes, describe

Use needles for the injection of illegal drugs? ○ Yes ○ No ○ Unknown

If Yes, describe

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

Phone Number - - **Date** / /